U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 16 July 2007

Case No. 2005-BLA-6127

In the Matter of

K. A.,

Claimant,

v.

KIMBERLY & K COAL CO.,

Employer,

and

EMPLOYERS INS. OF WAUSAU,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

Thomas W. Moak, Esq.
Moak & Nunnery, PSC
Prestonsburg, Kentucky
For the Claimant

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing or participate in this case after referral to this office, the Director is deemed to have waived any issue which it could have raised at any stage prior to the close of this record. By referring this matter for hearing, the District Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

Bonnie Hoskins, Esq., of record
Carl Brashear, Esq., at hearing
Hoskins Law Offices
Lexington, Kentucky
For the Employer

BEFORE: LARRY S. MERCK
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

Claimant filed his first application for benefits on August 16, 1991. (DX 1).[2] On September 30, 1992, by Decision and Order, Administrative Law Judge Daniel A. Sarno, Jr., denied benefits. *Id*. Claimant filed this subsequent application for benefits on August 11, 2004. (DX 4). The District Director issued a Proposed Decision and Order awarding benefits on April 26, 2005. (DX 39). On July 22, 2005, the District Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a hearing. (DX 43). A formal hearing was held on October 13, 2006, in Prestonsburg, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[3]

The issues in this case are:

[2] "DX" refers to Director's Exhibits, "EX" refers to Employer's Exhibits, "CX" refers to Claimant's Exhibits, and "TR" refers to the transcript of the hearing.

[3] At the hearing, Employer withdrew the following contested issues: 1) timeliness; 2) miner; 3) dependency; and 4) responsible operator. In addition, Employer and Claimant stipulated to at least twenty-five years of coal mine employment. Employer also maintains issues for appellate purposes only. (TR 9-11, 23-24).

1. Whether Claimant has pneumoconiosis as defined in the Act and regulations;

2. Whether Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether Claimant is totally disabled;

4. Whether Claimant's disability is due to pneumoconiosis; and,

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to § 725.309(d).

(TR 9-11, 23-24; DX 43).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

Claimant, K. A., was born on August 5, 1932. (DX 4). He has a ninth grade education. *Id.* He is married and he has no dependent children. (DX 12; TR 22).

At the hearing, the parties stipulated to at least twenty-five years of coal mine employment. (TR 9). Claimant's last coal mine employment was with Kimberly & K Coal Company for approximately three years, ending in 1989. (TR 14; DX 5, 7; EX 7). As a miner, Claimant worked primarily underground running loaders, roof bolters, and shoveling the "ribs". (TR 13-14; DX 5). He stated that he was exposed to significant amounts of coal dust in the aforementioned jobs. (TR 13). In 1989, Claimant ceased coal mine employment, primarily because of his breathing problems. (TR 15; DX 5). In 1992, Claimant received a State Black Lung settlement. (DX 9-11).

Claimant is treated by Dr. Lowell Martin for his breathing problems. (TR 15-16). Dr. Martin prescribed breathing medication, a nebulizer, and oxygen. (TR 16). Claimant cannot walk very far without experiencing breathing difficulties and he

has trouble walking on inclines. (TR 15-16). Additionally, Claimant suffered a heart attack thirty years ago and he currently takes medication for blood pressure problems. (TR 17-18).

Claimant testified at the hearing that he began smoking at approximately age twenty-eight and stopped at age forty-eight, at a rate of one pack of cigarettes a day. (TR 20). Claimant was deposed on February 9, 2005, and testified that he smoked about a pack of cigarettes a day for ten years, quitting in about 1960. (EX 7). In his medical report, dated September 24, 2004, Dr. Forehand recorded that Claimant smoked from 1950 to 1960 at a rate of one pack of cigarettes a day. (DX 16). Dr. Baker noted in his medical report, dated March 6, 2006, that Claimant's smoking history was unclear but he smoked somewhere between sixteen and twenty years at a rate of one pack of cigarettes a day, stopping at the age of forty-eight. (CX 1). Dr. Dahhan in his medical report, dated February 9, 2005, noted that Claimant smoked a pack of cigarettes a day for ten years, quitting twenty years earlier. (DX 33). Dr. Alam in his medical note, dated April 5, 2005, recorded that Claimant smoked for ten years at a rate of one pack of cigarettes a day, quitting twenty-five years earlier. (CX 2). Because the evidence regarding Claimant's smoking history is contradictory, I am unable to determine an exact smoking history.

Length of Coal Mine Employment:

The duration of a coal miner's employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated to at least twenty-five years of coal mine employment. (TR 9-11). Based upon my full review of the record, to include Claimant's Social Security tax earnings records, I accept the stipulation and credit Claimant with at least twenty-five years of coal mine employment, as that term is defined by the Act and Regulations. He last worked in the Nation's coal mines in 1989. (DX 4-5, 7).

Dependency:

On his application form, Claimant alleged two dependents for the purpose of benefit augmentation, namely his wife, L.A., whom he married on November 15, 1963, and his disabled son. (DX 4; TR 21). Claimant's official marriage record was admitted into the record. (DX 12). However, Claimant testified at the hearing that his son was not a dependent. (TR 22). Accordingly,

I find that Claimant has one dependent for the purpose of benefit augmentation.

Applicable Regulations:

Claimant filed this claim on August 11, 2004. (DX 4). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. In addition, the Amendments to the Part 718 regulations, which became effective on January 19, 2001, are also applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. §725.414(a)(2)(ii). Likewise, employers and the District Director are subject to similar limitations on affirmative and rebuttal evidence. § 725.414(a)(3).

Subsequent Claim:

Section 725.309(d) provides that a subsequent claim must be denied unless claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. § 725.309(d)(2). If Claimant establishes the existence of one of these conditions, he has demonstrated, as a matter of law, a material change. If he is successful in establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

Claimant's previous claim was a request for benefits which was ultimately denied by Judge Sarno on September 30, 1992. (DX

1). The current claim was filed on August 11, 2004, more than one year after the prior denial, so that it cannot be construed as a modification proceeding pursuant to § 725.310(a). Therefore, according to § 725.309(d), this claim must be denied on the basis of the prior denial unless there has been a change in an applicable condition of entitlement since the previous denial.

The previous claim was denied when it was determined that Claimant failed to establish the existence of pneumoconiosis. (DX 1). The Administrative Law Judge did not make any findings in respect to total disability or total disability due to pneumoconiosis; and as such, Claimant did not meet these elements of entitlement. Accordingly, the newly submitted medical evidence will be reviewed in order to determine whether any of the applicable conditions of entitlement have changed since the previous denial.

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to § 718.202, the miner can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in §§ 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under § 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with § 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

Dr. Forehand, a B-reader,[4] interpreted a September 28, 2004, x-ray as positive for pneumoconiosis with a 1/1 profusion. (DX

[4] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for

16). Dr. Forehand rated the x-ray film quality as "1". *Id.* Dr. Barrett, a Board-certified Radiologist and B-reader, re-read the x-ray for quality purposes only, also rating the film quality as "1". (DX 17). Dr. Halbert, a B-reader, interpreted the x-ray as having a profusion of 1/1; however, he stated that the opacities were "consistent with those seen in some types of pneumoconiosis such as asbestosis [; the opacities were] not consistent with coal workers pneumoconiosis." "[He saw] no evidence of coal workers' pneumoconiosis." (EX 5). Dr. Halbert rated the film quality as "1". *Id.* Dr. Repsher, a B-reader, interpreted the x-ray as negative for pneumoconiosis, rating the film quality as "3". (EX 1).

The Benefits Review Board ("Board") held that if a physician marks a film quality of "3," "U/R," or, in some cases, a "-," then the x-ray study may be accorded little or no probative value as it is of poor quality. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988). Therefore, I assign Dr. Repsher's interpretation no weight. Drs. Forehand and Halbert, who are B-readers, and Dr. Barrett, who is a Board-certified Radiologist and B-reader, gave the film quality a "1." Therefore, after weighing the film quality ratings made by these doctors and their qualifications, I find the x-ray film quality to be "1". Additionally, having taken the Doctors' qualifications into consideration, I find the evidence regarding this x-ray to be in equipoise.

Dr. Baker, a B-reader, interpreted a March 6, 2006, x-ray as positive for pneumoconiosis, with a 2/1 profusion. (CX 1). Dr. Repsher, a B-reader, stated that the profusion on the x-ray was 1/2; however, he interpreted the x-ray as negative for pneumoconiosis. (EX 9).[5] Having taken into consideration the qualifications of the doctors, I find the evidence regarding this x-ray in equipoise.

Dr. Dahhan, a B-reader, interpreted a February 5, 2005, x-ray as negative for pneumoconiosis. (DX 33). As no rebuttal

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Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).

[5] At the hearing, Employer was granted an additional forty-five days to submit a rebuttal reading of this x-ray. (TR 6-7). On November 6, 2006, Employer filed an interpretation of the x-ray, dated March 6, 2006, and it is admitted as EX 9.

evidence was admitted, I find this x-ray negative for pneumoconiosis.[6]

Claimant also provided an x-ray interpretation, dated March 9, 2005, by Dr. Kumar, a radiologist, from Claimant's treatment records. (CX 2). However, this x-ray does not conform to the standards set forth in the Regulations and will not be considered in this section. *See* § 718.102.

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist).

Additionally, it is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990). The United States Court of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. *Stanton v. Norfolk & Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993)).

In sum, I find that one x-ray is negative for pneumoconiosis and two are in equipoise. Accordingly, I find that Claimant has failed to establish, by a preponderance of the evidence, the existence of clinical pneumoconiosis pursuant to § 718.202(a)(1).

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

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[6] Employer noted a second reading of this x-ray by Dr. Repsher on its Black Lung Evidence Summary Form. However, Dr. Repsher's interpretation exceeds the evidentiary limitations of § 725.414. As Employer has not shown good cause for exceeding the limitations, Dr. Repsher's interpretation of this x-ray will not be considered.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

Under § 718.202(a)(4), the fourth and final method to establish pneumoconiosis, a determination of the disease may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201, which provides the following definition of pneumoconiosis:

> (a) For purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical or "clinical" pneumoconiosis and statutory or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthra-cosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.201.

Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Field v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.*

Dr. J. Randolph Forehand, a B-reader, examined Claimant on September 28, 2004, completed his medical report on November 24, 2004, provided a supplementary report, dated December 6, 2004, and was deposed on January 30, 2006. (DX 16, 20; EX 2). His complete medical workup included a chest x-ray, pulmonary function study, arterial blood gas analysis, and EKG. (DX 16). Dr. Forehand recorded that Claimant worked in underground coal mine employment for about twenty-seven years, working as a utility man and "a shooter, driller, and roof bolter." (DX 16; EX 2). He smoked one pack of cigarettes a day for ten years. (DX 16). Dr. Forehand recorded that Claimant suffers from cough with sputum production, shortness of breath upon exertion, night time wheezing, requiring the use of two pillows, chest pain on occasion, which is "made worse when exposed to extremes of temperature and humidity or dusty, smoky, moldy conditions[,]" and orthopnea. (DX 16; EX 2). A chest examination was normal except for crackles heard throughout and specifically at the "bases bilaterally". *Id.* EKG revealed cor pulmonale. Dr. Forehand interpreted Claimant's x-ray as positive for coal workers' pneumoconiosis, with a 1/1 profusion. Claimant's pulmonary function studies both before and after the administering of a bronchodilator were qualifying and reveal an

obstructive ventilatoy pattern. His arterial blood gas analysis was qualifying and revealed arterial hypoxemia. *Id.*

Dr. Forehand made the following diagnoses: 1) coal workers' pneumoconiosis – based on Claimant's chest x-ray, history of coal dust exposure, physical examination, arterial blood gas analysis, and EKG; 2) chronic bronchitis – based on history of cough with sputum production and pulmonary function study;, and (3) cor pulmonale based on EKG. (DX 16; EX 2). Dr. Forehand determined the etiology of his diagnoses to be Claimant's coal mine dust exposure and cigarette smoking. Dr. Forehand categorized Claimant's pulmonary impairment as "significant". (DX 16). He stated that "insufficient residual ventilatory and oxygen transfer capacity remain to return to last coal mining job. Unable to work. Totally and permanently disabled." *Id.* Dr. Forehand explained that "coal workers pneumoconiosis contribut[ed] to his respiratory impairment. [T]en years of smoking cigarettes having a lesser effect than coal worker's pneumoconiosis." *Id.*

In a clarification response, dated December 6, 2004, Dr. Forehand explained that Claimant's disabling pulmonary impairment was caused by a combination of "chronic bronchitis brought on by smoking cigarettes and coal workers' pneumoconiosis brought on by his coal mine employment. "[Claimant's] employment in underground coal mining has substantially aggravated his chronic bronchitis." (DX 20). Also, Claimant's underground coal mine employment caused coal workers' pneumoconiosis which scars the lungs and affects normal oxygenation of the blood. Additionally, chronic arterial hypoxemia causes cor pulmonale; Claimant's employment in underground coal mining has significantly contributed to his abnormal x-ray, abnormal blood gas study, and cor pulmonale. *Id.*

In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit held that a physician's opinion that the claimant's "obstructive ventilatory defect could have been caused by either smoking or coal dust exposure" should be viewed under the circumstances of that case as "tantamount to a finding that both coal dust exposure and smoking were operative factors and that it was impossible to allocate blame between them." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Court emphasized that such a finding was sufficient to establish that the claimant's pneumoconiosis arose out of his coal mine employment, stating that:

> [U]nder the statutory definition of pneumoconiosis, Cornett was not required to demonstrate that coal dust was the *only* cause of his current respiratory problems. He needed only show that he has a chronic respiratory and pulmonary impairment 'significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'

Id. at 576 (citing § 718.201)(emphasis in original).

The Court went on to find that the Administrative Law Judge improperly discounted the physicians' opinions, and emphasized that "accurately following the regulatory definition of pneumoconiosis cannot be grounds for rejecting a doctor's opinion." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Furthermore, in *Crockett Collieries, Inc. v. Barrett*, the Sixth Circuit affirmed an Administrative Law Judge's award of benefits. *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring). In *Barrett*, both Drs. Baker and Dahhan concluded that the miner suffered from a respiratory impairment. *Id.* at 356. However, they disagreed as to whether the impairment "could all be due to cigarette smoking or could be due to a combination of cigarette smoking and coal dust exposure." *Id*. Dr. Baker concluded that coal dust exposure "probably contributes to some extent in an undefinable portion" to the miner's pulmonary impairment. *Id.* The Court agreed with the Administrative Law Judge's reasoning, holding that after invoking the rebuttable presumption that the miner's legal pneumoconiosis arose out of coal dust exposure at § 718.203(b), the Administrative Law Judge properly found Dr. Baker's opinion sufficient, and not too equivocal, to support a finding that the miner suffered from pneumoconiosis arising out of coal mine employment. *Id.* at 358; *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.)(holding that the Administrative Law Judge properly credited a physician's opinion, which stated that the claimant's pneumoconiosis was related to coal dust exposure, by considering other possible factors, such as smoking, age, obesity, or hypertension.).

In this case, Dr. Forehand diagnosed clinical and legal pneumoconiosis, and unequivocally found that both diagnoses were causally related to dust exposure and cigarette smoking. (DX 16, 20; EX 2). In forming his opinion about clinical pneumoconiosis, Dr. Forehand relied on Claimant's physical exam, chest x-ray, qualifying arterial blood analysis, history, and EKG. He based

his opinion on legal pneumoconiosis; i.e., chronic bronchitis, on history of symptoms and pulmonary function tests. In *Church v. Eastern Assoc. Coal Corp.*, 21 B.L.R. 1-51 (1997), *rev'g in part and aff'g in part on recon.*, 20 B.L.R. 1-8 (1996), the Board reaffirmed its earlier holding that the administrative law judge properly analyzed the medical evidence under § 718.202(a)(4) in crediting the physicians' opinions that were supported by underlying objective studies. Moreover, the Board reiterated that "an administrative law judge may not discredit an opinion solely on the ground that it is based, in part, upon an x-ray reading which is at odds with the administrative law judge's finding with respect to the x-ray evidence of record." In so holding, the Board noted that the physician also based his finding on observations gathered during the time he physically examined Claimant.

In addition, a finding of pneumoconiosis under § 718.202(a)(4) "shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories." § 718.202(a)(4). Dr. Forehand expressly stated that he based Claimant's clinical and legal pneumoconiosis diagnoses on objective medical evidence including an x-ray which he interpreted as positive for pneumoconiosis, Claimant's history, physical examination, pulmonary function study, and arterial blood gas analysis. Therefore, because the opinion is based on objective medical evidence, as defined in § 718.201 to include medical testing and Claimant's medical and work history, I find Dr. Forehand's report well-reasoned and well-documented.

Dr. Glen Baker, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, physically examined Claimant on March 3, 2006. (CX 1). His medical workup included a chest x-ray, pulmonary function test, and an arterial blood gas study. Dr. Baker recorded that Claimant worked in underground coal mine employment for twenty-seven years and smoked somewhere between sixteen and twenty years, at a rate of one pack of cigarettes a day, stopping at approximately the age of forty-eight. Dr. Baker noted that for the last eight to ten years Claimant has suffered from daily cough with sputum production, daily wheezing, daily dyspnea, occasional chest pain, and orthopnea – which is aided by the use of two pillows. Claimant's chest examination was unremarkable. Under x-ray findings, Dr. Baker noted coal workers' pneumoconiosis, with a 2/1 profusion. (CX 1). His pulmonary function study was qualifying and revealed a moderate obstructive defect. The arterial blood gas analysis

was qualifying and revealed severe resting arterial hypoxemia. *Id.*

Dr. Baker made the following diagnoses: 1) coal workers' pneumoconiosis 2/1 – based on an abnormal x-ray and coal dust exposure; 2) chronic obstructive pulmonary disease ("COPD") with moderate obstructive defect – based on pulmonary function tests; 3) chronic bronchitis - based on history; 4) severe hypoxemia – based on results of arterial blood gas analysis; and 5) Ischemic heart disease based on history of prior myocardial infarction. (CX 1). He concluded that Claimant's coal workers' pneumoconiosis was caused by coal dust exposure, while his COPD, chronic bronchitis, and hypoxemia were caused by both coal dust exposure and cigarette smoking.

A diagnosis of pneumoconiosis based on a positive chest x-ray and history of dust exposure alone is not a well-documented and reasoned opinion. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Benefits Review Board permits discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-1405 (1985)). Acknowledging that Dr. Baker performed other physical and objective testing, he listed that he expressly relied on Claimant's positive x-ray and coal dust exposure for his clinical determination of pneumoconiosis. He failed to state how results from his other objective testing might have impacted his diagnosis of clinical pneumoconiosis. As Dr. Baker does not indicate any other reasons for his diagnosis of clinical pneumoconiosis beyond the x-ray and exposure history, I find his diagnosis of clinical pneumoconiosis is neither well-documented nor well-reasoned.

Dr. Baker's diagnosis of hypoxemia was based on Claimant's non-qualifying blood gas analysis. He noted that the etiology of Claimant's hypoxemia was coal dust exposure and cigarette smoking. (CX 1). Legal pneumoconiosis is defined as any chronic lung disease or impairment arising out of coal mine employment. § 718.201(a). Dr. Baker's diagnosis of "hypoxemia" does not fall within the regulatory definition, as it is not necessarily a chronic lung disease. Accordingly, Dr. Baker's diagnosis of hypoxemia is inadequate to constitute legal pneumoconiosis under the regulations.

As discussed, legal pneumoconiosis includes any chronic lung disease or impairment arising out of coal mine employment.

Dr. Baker diagnosed Claimant with COPD and chronic bronchitis, or legal pneumoconiosis, based on the qualifying results of a pulmonary function study. In his medical narrative, Dr. Baker explained how his consideration of Claimant's history of symptoms, occupational history, smoking history, physical examination, and the results of his objective medical testing support his finding that Claimant's COPD and chronic bronchitis are related to coal dust exposure and cigarette smoking. *Id.*

For the reasons discussed above, I find Dr. Baker's opinion regarding legal pneumoconiosis, i.e., COPD, and chronic bronchitis, well-reasoned and well-documented. *See Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring); *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000); *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.).

Dr. Baker opined that Claimant suffers from a moderate pulmonary impairment and severe resting arterial hypoxemia. (CX 1). He stated that Claimant would be unable to do the work of a coal miner or comparable work in a dust free environment. Dr. Baker concluded that Claimant's totally disabling impairment primarily related to "a combination of his coal dust exposure and cigarette smoking in a possibly 50/50 percentage, but it is difficult to give exact percentages with any degree of certainty." In sum, Dr. Baker explained that coal dust exposure and cigarette smoking both had a material adverse effect on his respiratory condition and contributed substantially to his total disability. For the reasons discussed, I find Dr. Baker's opinion that Claimant is totally disabled due to pneumoconiosis well-documented and well-reasoned.

Dr. A. Dahhan, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, conducted a physical examination of Claimant on February 5, 2005, and was deposed on November 14, 2005. (DX 33; EX 4). His complete medical workup included a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. He recorded that Claimant worked in the coal mine industry for twenty-seven years, stopping in 1989 when he suffered a heart attack. He worked twenty-four years underground as a roof bolter, shuttle car operator, and as an electrician. He worked three years above ground operating battery equipment. Dr. Dahhan noted that Claimant smoked a pack of cigarettes a day for ten years, quitting twenty years earlier. Dr. Dahhan recorded that Claimant suffers from morning cough, occasional wheezing, and dyspnea on exertion, and he sleeps using two pillows. Claimant uses a nebulizer to help him breath and oxygen

two to three hours a night. A chest exam was normal, except for "scattered expiratory wheeze with no crepitation or pleural rubs." *Id.* An EKG showed "regular sinus rhythm with left anterior hemi block." *Id.* Dr. Dahhan interpreted the chest x-ray as negative for pneumoconiosis; however, he opined that the x-ray "showed hyperinflated lungs consistent with emphysema." *Id.* The arterial blood gas analysis was qualifying, before and after exercise, and showed minimum hypoxemia at rest and moderate hypoxemia after exercise. The pulmonary function studies showed "a moderately severe obstructive ventilatory defect with response to bronchodilator therapy." *Id.* The pulmonary function tests produced qualifying results both before and after the administering of a bronchodilator. (DX 33).

Dr. Dahhan opined that Claimant does not have occupational pneumoconiosis or any other disease arising out of coal dust exposure.(DX 33, EX 4). Based on his review of Claimant's occupational, clinical, radiological, and physiological evaluation, he made the following conclusions: "there are insufficient objective findings to justify diagnosis of coal worker's pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, obstructive abnormality on spirometry testing with response to bronchodilator therapy, adequate blood gas exchange mechanisms at rest and after exercise and negative x-ray reading for pneumoconiosis." (DX 33).

Further, Dr. Dahhan opined that Claimant's ventilatory defect did not arise from coal dust exposure because he had not had any exposure to coal dust since 1989 and any industrial bronchitis he my have had would have ceased. (DX 33). His pulmonary impairment is severe and disabling but rarely seen "secondary to the inhalation of coal dust, per se." Dr. Dahhan opined that Claimant does not have the physical ability to continue his previous coal mine employment. Also, he believes that Claimant's response to bronchodilator therapy indicates that it is not a fixed condition, which is inconsistent with the permanent adverse affects of coal dust on the respiratory system. He added that Claimant also has coronary artery disease, but that it is not in any way related to his exposure to coal dust. *Id.* At his deposition, Dr. Dahhan testified to the same. (EX 4).

In *Consolidation Coal Co. v. Swiger*, the Fourth Circuit Court of Appeals upheld an Administrative Law Judge's finding that the reversibility of pulmonary function values after use of a bronchodilator does not preclude the presence of disabling

coal workers' pneumoconiosis. *Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.). In particular, the court noted the following:

> All the experts agree that pneumoconiosis is a fixed condition and therefore any lung impairment caused by coal dust would not be susceptible to bronchodilator therapy. In this case, although Swiger's condition improved when given a bronchodilator, the fact that he experienced a disabling residual impairment suggested that a combination of factors was causing his pulmonary condition. As a trier of fact, the ALJ 'must evaluate the evidence, weigh it, and draw his own conclusions.' (citation omitted). Therefore, the ALJ could rightfully conclude that the presence of the residual fully disabling impairment suggested that coal mine dust was a contributing cause of Swiger's condition. (citation omitted).

Id.

Moreover, in *Crockett Collieries, Inc. v. Director, OWCP [Barrett]*, the Sixth Circuit Court of Appeals agreed with the administrative law judge's weighing of the medical evidence and affirmed the claimant's award of benefits, noting that:

> In rejecting Dr. Dahhan's opinion, the ALJ found that Dahhan had not adequately explained why Barrett's responsiveness to treatment with bronchodilators necessarily eliminated a finding of legal pneumoconiosis, and had not adequately explained 'why he believes that coal dust exposure did not exacerbate (the miner's) allegedly smoking-related impairments.'

Crockett Collieries, Inc. v. Director, OWCP [Barrett], 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring); *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.).

In the present case, Dr. Dahhan failed to sufficiently explain the significance of Claimant's responsiveness to bronchodilators, particularly because Claimant's improved results are still qualifying under the regulations.

In addition, in *Cannelton Industries, Inc. v. Director, OWCP [Frye],* the Fourth Circuit concluded that the ALJ properly accorded less weight to the opinion of Dr. Forehand, who found that the miner was totally disabled due to smoking-induced bronchitis, but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. In affirming the ALJ, the court noted that "Dr. Forehand erred by assuming that the negative x-rays (underlying his opinion) necessarily ruled out that (the miner's) bronchitis was caused by coal mine dust ...." *Cannelton Industries, Inc. v. Director, OWCP [Frye],* Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub.).

In the present case, Dr. Dahhan did not adequately explain why he believes that coal dust exposure did not contribute to Claimant's impairment. Instead he chose to rely solely on smoking history, apparently without considering whether both cigarette smoking and coal dust exposure had a concurrent effect in causing chronic obstructive lung disease.

In *Freeman United Coal Mining Co. v. Summers*, the Seventh Circuit Court of Appeals concluded that the Administrative Law Judge properly gave less weight to the opinion of a physician "based on a finding that they were not supported by adequate data or sound analysis." *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001). Importantly, the Court made reference to the comments to the amended regulations and stated the following:

> Dr. Fino stated in his written report of August 30, 1998 that 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' (citation omitted). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'

Id. at n. 7.

In the present case, Dr. Dahhan similarly states that, because of their obstructive nature, Claimant's respiratory problems are not related to his coal dust exposure. However, as discussed *supra*, the regulatory definition of legal pneumoconiosis expressly "includes, but is not limited to, any

chronic restrictive *or obstructive* pulmonary disease arising out of coal mine employment." § 718.201(a)(2)(emphasis added). Because Dr. Dahhan's view is not in accord with the general standpoint of the medical and scientific communities, Dr. Dahhan's reasoning is insufficient to support his opinion that Miner's COPD is not related to his coal mine employment.

For any of the reasons stated above, I find Dr. Dahhan's opinion regarding legal pneumoconiosis insufficiently reasoned and not supported by the objective medical evidence and I grant it little probative weight.

Dr. James Castle, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, prepared a consultative report on March 1, 2005, and an addendum to his report on October 9, 2006.[7] (DX 36; EX 3). In his initial report Dr. Castle reviewed Dr. Forehand's initial medical report and his supplement to that report, along with all the medical testing. (DX 36).

Based on his review of the aforementioned data, Dr. Castle opined that, to a medical certainty, Claimant "probably does not suffer from coal worker's pneumoconiosis." (DX 36). He based his conclusion on the following: 1) Claimant worked for twenty-seven years in the coal mine employment and had a smoking history of ten pack years. This exposure history was enough to cause Claimant "to develop. . . chronic bronchitis/emphysema and or lung cancer and or atherosclerotic cardiovascular disease if he were a susceptible host[;]" 2) Claimant's history indicated a prior heart attack and cardiovascular disease which is a risk factor for developing "pulmonary symptoms[;]" 3) the pulmonary function studies, although not totally valid according to Dr. Castle, "show evidence of at least moderate markedly reversible airway obstruction associated with marked hyperinflation and gas trapping[]" and a reduced diffusing capacity. *Id.* He further opined that these results are not typical of coal worker's pneumoconiosis, which causes a "mixed, irreversible obstructive and restrictive ventilatory defect[;]" they are more typical of tobacco use, which causes "induced airway obstruction with a significant asthmatic component[;]" 4) Claimant's hypoxemia, which became worse with exercise, is "typically seen in individuals with significant tobacco smoke

[7] On October 24, 2006, Employer filed an additional addendum to Dr. Castle's report, dated October 16, 2006. I have marked this exhibit as EX 10 for Identification. Employer has not shown good cause as to why this evidence should be admitted post-hearing; therefore, it was excluded from consideration. § 725.456(b)(3).

induced obstruction such as pulmonary emphysema[;]" and 5) finally, the EKG did not show specific evidence of cor pulmonale but did show evidence of a prior heart attack. *Id.*

In his supplemental report, dated October 9, 2006, Dr. Castle reviewed the following additional information: 1) his own report, dated April 1, 2005; 2) x-ray report by Dr. Repsher, of film dated September 28, 2005; 3) Dr. Dahhan's medical report along with his objective tests and deposition testimony; and 4) Dr. Forehand's deposition testimony. Dr. Castle adhered to his original analysis and opined that Claimant did not suffer from coal worker's pneumoconiosis. (EX 3). Additionally, he opined that Claimant was totally disabled from a pulmonary perspective and unable to perform his previous coal mine employment; however, all of his disability was related to "his tobacco induced airway obstruction and bronchial asthma. It is also possible that [Claimant] is permanently and totally disabled as a result of coronary artery disease." (EX 3).

Dr. Castle's reliance on Claimant's improvement in pulmonary function tests post-bronchodilator is unreasoned, as discussed above in regards to Dr. Dahhan's report. Dr. Castle does not account for the fact that both cigarette smoking and coal dust exposure could have played a part in Claimant's condition. Reversibility of pulmonary function is not necessarily an indication that a coal dust-related impairment does not exist, particularly when Claimant's tests continue to produce qualifying results post-bronchodilator. See *Crockett Collieries, Inc. v. Director, OWCP [Barrett]*, 478 F.3d 350, 2007 (6th Cir. 2007) (J. Rogers, concurring); *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000); *Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.); *see also Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.).

In addition, Dr. Castle does not adequately address the issue of legal pneumoconiosis. In fact, Dr. Castle does not adequately explain or consider whether Claimant's pulmonary disease was contributed to, or aggravated by, his exposure to coal dust. In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit rejected this analysis, holding that a determination that coal dust exposure did not contribute to or aggravate the claimant's respiratory problems should require an explanation by the physician as to why coal mine employment was eliminated as a possible cause. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Moreover, in *Crockett Collieries, Inc., v. Barrett*, the Sixth Circuit noted that the Administrative Law Judge had properly invoked the presumption of causation contained in § 718.203(b) because the claimant had worked in coal mine employment for more than ten years. *Crockett Collieries, Inc., v. Barrett*, 478 F.3d 350, 355 (6th Cir. 2007). The presumption of causation is also invoked in this case, as I have credited Claimant with at least twenty-five years of coal mine employment, which was stipulated to by both parties at the hearing. Therefore, Claimant is entitled to the presumption that his COPD, or legal pneumoconiosis, arose out of his coal mine

In sum, any of the reasons discussed in detail above would be sufficient to discount Dr. Castle's opinion in this case. However, I rely on all of the foregoing reasons to find that Dr. Castle's opinion is not well-reasoned and grant it little weight.

Claimant submitted nineteen pages of medical notes and records which included: an x-ray, CT scan, pulmonary function tests, EKG, and medical consultation reports covering the period March 9, 2005, until April 13, 2005. (CX 2). In Dr. Alam's medical evaluation, dated March 9, 2005, he recorded that Claimant worked in the mines for twenty-seven years and smoked for ten years, quitting twenty-five years ago. He noted that Claimant suffers from chronic cough with sputum production, dyspnea on exertion, and wheezing on exertion. He recorded that Claimant past medical history revealed hypertension heart attack, and COPD. Examination of the lungs revealed hyperexpanded lungs with little rhonchi and no pleural rub but mild wheezing noted upon auscultation. A chest x-ray "showed bibasilar atelectasis." *Id.* An EKG "revealed LBBB with no acute ST T wave changes." *Id.* An arterial blood gas analysis "showed pH 7.44 PCO2 35. PO2 60 SATS 91%." *Id.* Pulmonary function tests revealed severe airflow obstruction. Dr. Alam's conclusion, as stated in his medical note, dated April 13, 2005, was that Claimant suffered from the following: 1) chronic dyspnea-but stable; and 2) severe COPD with coal workers' pneumoconiosis. *Id.*

In *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.), the Board held that the Administrative Law Judge did not abuse his discretion in excluding CT-scan evidence proffered by the employer based on the employer's failure to demonstrate that the test was (1) medically acceptable, and (2) relevant to establishing or refuting the claimant's entitlement to benefits. In accepting the Director's

position on this issue, the Board held that, because CT-scans are not covered by specific quality standards under the regulations, the proffering party bears the burden of demonstrating that the CT-scans were "medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits." *Id.*; *see also* § 718.107(b). In the present case, Claimant did not show that the CT scan was medically acceptable and relevant to establishing or refuting his entitlement of benefits. As such, the CT scan will not be considered.

Claimant also provided an x-ray interpretation from his treatment records, dated March 9, 2005, by Dr. Kumar, a Radiologist. (CX 2). However, this x-ray does not conform to the standards set forth in the Regulations and will not be considered in this section. *See* § 718.102. Also, two pulmonary function studies were included in Dr. Alam's treatment notes but they did not contain three tracings. (CX 2). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Accordingly, I grant the pulmonary function studies in Dr. Alam's treatment notes no weight.

Additionally, Dr. Alam failed to adequately explain how his physical findings and symptomatology were supportive of a finding of COPD. Therefore, for the reasons discussed, I assign Dr. Alam's medical opinion little weight.

For the reasons previously discussed, I find Dr. Forehand's opinion as to both clinical and legal pneumoconiosis well-documented and well-reasoned and Dr. Baker's medical opinion, as to legal pneumoconiosis, well-documented and well-reasoned and give them full probative weight on the aforementioned issues. I give the medical opinions of Drs. Dahhan, Castle, and Alam less weight for the reasons discussed. Weighing the probative newly submitted evidence together, I find that Claimant has established, by a preponderance of the evidence, the existence of pneumoconiosis per § 718.202(a)(4).

In sum, I find that Claimant has not proved the existence of pneumoconiosis pursuant to § 718.202(a)(1-3), but has proved the existence of pneumoconiosis pursuant to § 718.202(a)(4). Therefore, as Claimant has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the previous claim became final, the entire record must be reviewed and considered to determine

whether Claimant is entitled to benefits under the Act. § 725.309.

Pneumoconiosis (Full Review):

Claimant's reviewable previous claim was filed on August 16, 1991. (DX 1). The medical evidence in the first claim is dated prior to January 1992. The Board has held that it is proper to afford the results of recent medical testing more weight than earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the medical evidence in Claimant's first claim is more than twelve years older than the newly submitted evidence (DX 1), I grant great weight to the more recent medical evidence and rely on it in finding that Claimant has established the existence of pneumoconiosis, for the reasons discussed above.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment:

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); § 718.203(b).

In *Kiser v. L&J Equipment Co.*, 23 B.L.R. 1-246, 1-259 n. 18 (2006), the Board cited to *Andersen v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006) and *Henley v. Cowan & Co.*, 21 B.L.R. 1-147, 1-151 (1999) and agreed with the Director's position that, if an administrative law judge finds the existence of legal pneumoconiosis, then he or she need not separately determine the etiology of the disease at § 718.203 because the findings at § 718.202(a)(4) will necessarily subsume that inquiry. Therefore, because I have found that Claimant has established that his legal pneumoconiosis arose out of his coal mine employment, a separate finding under § 718.203 is unnecessary in this case.[8]

[8] Even if it were necessary for Claimant to establish causation under § 718.203, based on the evidence of record, Claimant is entitled to the rebuttable interim presumption outlined in § 718.203(b), because he has established pneumoconiosis and that he worked in the coal mines for at least

Total Disability (Full Review):

Total disability is defined as Claimant's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the Claimant's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a Claimant shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987). Furthermore, the Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[9] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[10] or MVV[11] values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B. The record consists of five pulmonary function studies, pre- and post-bronchodilator

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twenty-five years. As Employer's evidence is insufficient to rebut the presumption, Claimant has established that his pneumoconiosis arose out of his coal mine employment.

[9] Forced expiratory volume in one second.

[10] Forced vital capacity.

[11] Maximum voluntary ventilation.

tests conducted on September 28, 2004, and February 5, 2005, and a pre-bronchodilator test on March 6, 2006.[12] (DX 16, 33; CX 1). The September 28, 2004, tests were validated by Dr. Mettu. (DX 16). These three pulmonary function tests were all qualifying. The remaining two pulmonary function studies were included in Dr. Alam's treatment notes but they did not contain three tracings. (CX 2). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Accordingly, as discussed *supra*, I grant the pulmonary function studies in Dr. Alam's treatment notes no weight.

Because the evidence submitted as part of Claimant's initial claim is more than twelve years older than the newly submitted evidence, I rely on the more recent pulmonary function studies. Thus, I find the pulmonary function study evidence of record establishes total disability pursuant to § 718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. Three studies have been entered into the record. (DX 16, 33; CX 1). The September 28, 2004, study was validated by Dr. Mettu. (DX 16). The study conducted on February 5, 2005, is non-conforming pursuant to § 718.105(c)(2). (DX 33). The remaining two studies are qualifying. (DX 16; CX 1).

Because the evidence submitted as part of Claimant's previous claim is more than twelve years older than the newly submitted evidence of record, I rely on the more recent arterial blood gas analyses. Thus, I find the arterial blood gas evidence of record establishes total disability pursuant to § 718.204(b)(2)(i).

[12] The fact-finder must resolve conflicting heights of Claimant recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). After reviewing all three height determinations, I find Claimant's height to be 68.5 inches.

A miner's total disability may be established where the miner has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). The EKG which was part of Dr. Forehand's medical workup revealed a "normal sinus rhythm[,] right superior axis deviation[,] pulmonary disease pattern[,] inferior infarct[ion, and] age undetermined." (DX 16). Based on these results, Dr. Forehand diagnosed cor puomonale with an etiology of cigarette smoking and coal dust exposure. *Id*. Drs. Baker, Dahhan, Castle, and Alam all agree that Claimant has heart disease but did not diagnose cor pulmonale. Dr. Forehand does not adequately explain how Claimant's symptomology and the objective evidence support a finding of cor pulmonale. Accordingly, I find that Claimant has failed to prove that he suffers from cor pulmonale by a preponderance of the evidence.

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), § 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work.

All of the physicians of record who provided an opinion as to total disability, Drs. Forehand, Baker, Dahhan, and Castle, opined that Claimant is totally disabled due to his pulmonary condition. (DX 16, 33, 36; CX 1; EX 3). All of the physicians based their total disability opinions on objective medical testing, clinical observations, and Claimant's history. *Id.* Thus, I find that the medical reports of record support a finding of total disability. Therefore, Claimant has established total disability pursuant to § 718.204(b)(2)(iv).

In sum, I rely on the medical reports, along with the qualifying pulmonary function studies and arterial blood gas analysis, to find total disability has been established pursuant to § 718.204.

Total Disability Due to Pneumoconiosis:

The regulations state that a claimant "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis ... is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." § 718.204(c)(1).

Pneumoconiosis is considered a "substantially contributing cause" of the claimant's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1).

In interpreting this requirement, the United States Court of Appeals for the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). Claimant must prove total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2).

The Board has held that it was proper for an administrative law judge to accord less weight to physicians' opinions, which concluded that pneumoconiosis did not contribute to the miner's disability, on grounds that the physicians did not diagnose pneumoconiosis. *See Osborne v. Clinchfield Coal Co.*, BRB No. 96-1523 BLA (Apr. 30, 1998) (*en banc on recon.*)(unpub.).

Dr. Dahhan examined Claimant on February 5, 2005. (DX 33). His report included medical testing, clinical observations, and Claimant's history. He opined that there were insufficient objective findings to justify a diagnosis of coal workers' pneumoconiosis. Moreover, he noted that none of Claimant's respiratory/pulmonary diseases were due to the inhalation of coal dust. Furthermore, Dr. Dahhan diagnosed Claimant as being totally disabled due to a smoking-related pulmonary impairment, not an impairment caused by coal dust exposure. *Id.* Dr. Dahhan reiterated these opinions during his November 14, 2005, deposition. (EX 4).

Dr. Castle prepared a consultative medical report on March 1, 2005. (DX 36). His report reviewed the Department-sponsored testing and report by Dr. Forehand, along with all validation of the testing. He stated that the evidence did not justify a finding of coal workers' pneumoconiosis. However, Dr. Castle diagnosed Claimant as being totally disabled due to a pulmonary impairment that was caused by cigarette smoking and asthma, but not coal dust exposure. Dr. Castle provided a supplemental

report on October 9, 2006. (EX 3). He reviewed his own report, Dr. Repsher's interpretation of the September 28, 2004 x-ray, Dr. Dahhan's medical report, including relevant objective medical testing, Dr. Dahhan's deposition testimony, and Dr. Forehand's deposition testimony. Dr. Castle's opinion as to coal workers' pneumoconiosis remained unchanged, and he continued to opine that Claimant's total disability resulted from a smoking-related pulmonary impairment.

As Drs. Dahhan and Castle failed to diagnose pneumoconiosis, contrary to my findings, I find Dr. Dahhan's and Dr. Castle's medical reports unreasoned and give them little weight on the issue of total disability due to pneumoconiosis.

Claimant submitted Dr. Alam's treatment notes. (CX 2). These records fail to contain any opinion as to total disability due to pneumoconiosis, and as such, I grant them little weight on the issue of total disability due to pneumoconiosis.

Dr. Forehand examined Claimant on September 28, 2004. (DX 16). His report included a positive x-ray reading, a qualifying pulmonary function study, a qualifying arterial blood gas analysis, clinical observations, and Claimant's histories of approximately ten years smoking and twenty-seven in underground coal mine employment. He diagnosed both clinical and legal pneumoconiosis based on the qualifying medical testing. Furthermore, he also noted Claimant was totally disabled as also shown by the medical testing. Dr. Forehand explained that "coal workers pneumoconiosis contribut[ed] substantially to [his] respiratory impairment. 10 years of smoking cigarettes having a lesser effect than coal workers' pneumoconiosis." Dr. Forehand testified to the same at his January 30, 2006, deposition. (EX 2). For the reasons discussed, *supra*, I find Dr. Forehand's medical opinion well-documented and well reasoned and I grant it full probative weight.

Dr. Baker examined Claimant on March 6, 2006. (CX 1). His report included a positive x-ray reading, a qualifying pulmonary function study, a qualifying arterial blood gas analysis, clinical observations, and Claimant's histories of approximately twenty years smoking and twenty-seven years in underground coal mine employment. He diagnosed both clinical and legal pneumoconiosis based on the qualifying medical testing. Furthermore, he also noted Claimant was totally disabled as also shown by the medical testing. Dr. Baker explained that coal workers' pneumoconiosis and cigarette smoke both had a material adverse effect on Claimant's respiratory condition and

contributed to his total disability. For the reasons discussed, *supra*, I find Dr. Baker's opinion regarding total disability due to pneumoconiosis well-reasoned and well-documented.

I continue to rely on the more recent probative evidence from Claimant's current claim. Therefore, based on the well-reasoned and well-documented reports of Drs. Forehand and Baker, I find that Claimant has established total disability due to pneumoconiosis.

Entitlement:

Claimant proved a material change in condition since the prior denial of benefits. In addition, Claimant has established pneumoconiosis arising out of coal mine employment and total disability due to pneumoconiosis; and therefore, he is entitled to benefits under the Act.

Date of Entitlement:

Section 725.503 provides that benefits are payable to a miner who is entitled beginning with the month of the onset of total disability due to pneumoconiosis. Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed.

The record in this case does not contain any medical evidence establishing exactly when Claimant became totally disabled. Therefore, payment of benefits is established as of August 2004, the month and year in which Claimant filed this claim for benefits.

Attorney's Fees:

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of thirty (30) days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director,* 8 BLR 2-1 (1985). The application must conform to §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including Claimant and Solicitor as counsel for the Director. Parties so served shall have twenty (20) days following receipt of any such application within which to file their objections.

Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is HEREBY ORDERED that

1. The claim of K. A. for benefits under the Act is hereby GRANTED;

2. Kimberly & K Coal Co., as insured by Employers Insurance of Wausau, shall pay K. A. all benefits to which he is entitled to under the Act;

3. Kimberly & K Coal Co., as insured by Employers Insurance of Wausau, shall refund to the Black Lung Disability Trust Fund all benefits, plus interest, if previously paid on behalf of K. A.; and,

4. Kimberly & K Coal Co., as insured by Employers Insurance of Wausau, shall pay Claimant's attorney, Thomas W. Moak, fees and expenses to be established in a supplemental decision and order.

A

LARRY S. MERCK
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the District Director's office. *See* §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to § 725.479(a).